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Author(s): Bruce G. Link
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UNDERSTANDING LABELING EFFECTS IN THE AREA OF MENTAL DISORDERS: AN ASSESSMENT OF THE EFFECTS OF EXPECTATIONS OF REJECTION*

BRUCE G. LINK
Columbia University and New York State Psychiatric Institute

This paper hypothesizes that official labeling gives personal relevance to an individual's beliefs about how others respond to mental patients. According to this view, people develop conceptions of what others think of mental patients long before they become patients. These conceptions include the belief that others devalue and discriminate against mental patients. When people enter psychiatric treatment and are labeled, these beliefs become personally applicable and lead to self-devaluation and/or the fear of rejection by others. Such reactions may have negative effects on both psychological and social functioning. This hypothesis was tested by comparing samples of community residents and psychiatric patients from the Washington Heights section of New York city. Five groups were formed (1) first-treatment contact patients, (2) repeat-treatment contact patients, (3) formerly treated community residents, (4) untreated community cases, and (5) community residents with no evidence of severe psychopathology. These groups were administered a scale that measured beliefs that mental patients would be devalued and discriminated against by most people. Scores on this scale were associated with demoralization, income loss, and unemployment in labeled groups but not in unlabeled groups. The results suggest that labeling may produce negative outcomes like those specified by the classic concept of secondary deviance.

The debate over the consequences of labeling as it applies to mental disorder has been hampered by an inordinate concern with the proposition that labeling produces full-blown mental illness and by a failure to consider the mechanisms through which labeling may affect psychiatric patients adversely. Link (1982) addressed the overemphasis on the etiological aspects of labeling by arguing that labeling can affect persons' lives in many ways other than by directly producing mental disorder. He showed that treated (labeled) cases of psychiatric disorder have less income and are more likely to be underemployed than similarly impaired untreated (unlabeled) cases with comparable background characteristics.

Despite this evidence, critics remain skeptical of results purporting to show labeling effects because such findings are not consistent with their positions concerning the mechanism of direct discrimination against labeled individuals. These critics claim that rejection by others is of little importance (Crocetti, Spiro, and Siassi 1974; Gove 1982, p. 280) because the reported incidence of overt discrimination due to labeling is low (Gove and Fain 1973; Huffine and Clausen 1979) and because rejection that does occur is more likely due to the ex-patient's aberrant behavior than to the effects of labeling (Schwartz, Myers, and Astrachan 1974; Lehman, Joy, Kreisman, and Simmens 1976; Kirk 1974; Huffine and Clausen 1979). Drawing on such evidence, Gove, summarizes the importance of labeling and stigma: "Most mental patients experience some stigma, however, in the vast majority of cases the stigma appears to be transitory and does not appear to pose a severe problem" (1982, p. 280); "Briefly put, labeling theory points to processes that exist but their overall impact is small" (1980, p. 268). Even so, criticisms of the labeling approach on which Gove's summations are based focus on the mechanism of direct discrimination, leaving open the possibility that labeling effects may arise through other, more subtle mechanisms. This paper assesses empirically one such mechanism—psychiatric patients' expectations of being devalued and discriminated against by others.

* Direct all correspondence to Bruce G. Link, Psychiatric Epidemiology, Columbia University, 100 Haven Avenue, New York, NY 10032.

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PATIENTS' EXPECTATIONS OF DEVALUATION AND DISCRIMINATION

In his original formulation of the labeling perspective, Scheff (1966) relied heavily on the assumption that individuals internalize cultural stereotypes of mental illness. These stereotypes become the "guiding imagery for action" when societal reactions crystallize around displays of rule breaking, and mental illness is the result. Unfortunately, Scheff's ideas on the importance of internalized beliefs about mental illness have been rejected by some who do not believe in the larger causal implications he assigned to the processes involved.

Internalized expectations of rejection affect labeled individuals in the following manner. Typically, long before people become psychiatric patients they have formed conceptions of what it means to be a mental patient. Scheff (1966) emphasized that jokes, cartoons, and the reporting of mental patient status by the media can influence conceptions of mental illness. Gerbner (1980), for example, has shown that individuals identified as mentally ill in television dramas are more likely to be violent than those not so identified. George Herbert Mead (1934) conceptualized the process of forming internalized conceptions of a variety of behaviors, objects, and attributes as a key component of socialization. He asserted that individuals learn the attitudes of the community toward many aspects of their environment and internalize them in the form of what he called the "generalized other."

Mead's generalized other includes two components when the label "mental patient" is at issue. "Devaluation" arises from Cumming and Cumming's (1965) notion of stigma as "loss of status" and from Goffman's (1963) ideas about the "discrediting" nature of a stigma. Closely related is the idea of "discrimination" as suggested by the extensive "social distance" tradition (cf. Link, Cullen, Frank, and Wozniak forthcoming). Consistent with these ideas, I am interested in the extent to which people believe that most others devalue and discriminate against mental patients. Following Scheff (1966), Gerbner (1980), and others (cf. Link and Cullen 1983), I expect that people will generally, although not uniformly, perceive the community attitude toward mental patients to be negative.

These conceptions take on new relevance when people become psychiatric patients for the first time. An official label gives personal relevance to their views about the community attitude toward mental patients. What once seemed to be an innocuous array of beliefs about people's attitudes toward mental patients now become applicable personally and no longer innocuous. In other words, official labeling can transform a person's beliefs about the devaluation and discrimination of mental patients into an *expectation of rejection*.

Negative consequences can arise through at least two social psychological mechanisms. First, individuals who become mental patients may devalue themselves because they now belong to a category that they believe most people view negatively. Second, patients may be concerned about how others will respond to them and therefore engage in defenses that lead to strained interaction, isolation, and other negative consequences. Both processes involve Mead's generalized other (Turner 1986). In the first case, self-concept and self-esteem are affected as people turn the perceived negative views of others onto themselves. In the second, the process of "imaginative rehearsal" causes individuals to be constrained by their perceptions of others' likely responses to them. These two processes are closely intertwined (Turner 1986), and in the present study their effects cannot be estimated separately. *Both* processes, however, require official labeling to make the perceived community attitude personally relevant, and thus both imply the importance of labeling for any negative consequences.

CONSEQUENCES OF EXPECTATIONS OF REJECTION

I test the foregoing reasoning about labeling effects with respect to two sets of specific hypotheses. First, in keeping with the notion that self-devaluation may be involved, I employ a measure of psychological distress or "demoralization." Second, with respect to social functioning, I hypothesize that beliefs about devaluation and discrimination will influence patients' capacities to obtain jobs and earn income, either because they devalue themselves and thus become less effective or because they actively fear the responses of others and withdraw or engage in other protective maneuvers that limit opportunity.

Demoralization

The concept of demoralization was derived independently by two socially oriented psychiatrists, Harry Stack Sullivan (1941) and Jerome Frank (1973). Sullivan wrote in the context of World War II on the breakdown of morale among combat troups and civilian victims of war. Frank also examined extreme situations, but focused his attention on an attempt to understand the common core of psychotherapeutic interventions and how it alleviated suffering. Despite the different angles from which they considered demoralization, similar themes run through their formulations.

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The first similarity occurs in their descriptions. Both theorists emphasize the erosion of self-esteem, along with feelings of helplessness and hopelessness, and a pattern of confusion in thought processes which reduces adaptive thinking. Both descriptions also involve dysphoric mood, pessimistic ruminations about the future, and other symptoms similar to those found in severely depressed people (Frank 1973; Sullivan 1941). Dohrenwend, Shrout, Egri, and Mendelsohn (1980) add validity to these constructs by showing that measures corresponding to components of demoralization cluster empirically.

More important for this paper are the convergences in Frank's and Sullivan's notions about the factors that produce demoralization. Frank directs attention to what he calls a person's "assumptive world," a "set of more or less implicit assumptions about himself and the nature of the world in which he lives, enabling him to predict the behavior of others and the outcome of his own actions" (Frank 1973, p. 27). According to Frank, demoralization results when an individual recognizes that components of the assumptive world, expectations of oneself, or perceived expectations of others are no longer tenable. In the same vein, Sullivan (1941, p. 282) draws attention to the breakdown of cherished beliefs about one's place in the world: "It seems that people become acutely demoralized under circumstances in which an implicitly trusted universe collapses; when an elaborate complex of interlocking and mutually supporting and dependent beliefs, convictions, faiths, and so on, suddenly proves to be built entirely on figments of self deception. An event suddenly shows that the universe does not make sense and one finds oneself badly demoralized."

Drawing on Frank and Sullivan, this study tests the hypothesis that psychiatric patients' expectations of rejection produce demoralization. Individuals who enter treatment and believe that most people will devalue and discriminate against them as a result are exposed to the causal factors that Frank and Sullivan hypothesized to be important. Such persons believe that as a result of becoming psychiatric patients, others will find them less intelligent, less likely to have important things to say, and less worthy of trust. They believe that others will discriminate against them as friends, workers, or lovers. Their "assumptive world," their cherished beliefs about their standing in the community, are called into question. Demoralization is the likely result.

Earned Income and Employment Status

Labeling processes may also produce negative consequences in the world of work. These can occur through an extension of the reasoning concerning demoralization or the "self-devaluation—self-hate" mechanism. If patients believe that they have assumed a status that is viewed negatively, self-esteem and self-efficacy can be affected to such an extent that work performance is impaired.

A second mechanism involves concern about the responses of others. Experimental studies have demonstrated that such concern can lead to strained interactions and negative evaluations by others (Farina, Allen, and Saul 1968; Farina, Gliha, Boudreau, Allen, and Sherman 1971). In studies of patients (1971) and nonpatients (1968), Farina and his colleagues manipulated their subjects' opportunity to worry about others' responses by randomly assigning subjects to one of two conditions. In one, subjects believed that a person with whom they were about to interact had been told that they had been hospitalized. In the other, subjects believed that this person had no such knowledge. Even though the partners in interaction were always given the same neutral information, subjects who believed that the other person knew about their hospitalization behaved in ways that evoked negative responses. Farina et al.'s (1971) study demonstrated these unfortunate effects in a situation explicitly designed to mimic job searching, thus indicating that patient's work functioning can be impaired by these processes.

Negative consequences can also result through defensive strategies designed to protect individuals from the negative reactions they fear (Angermeyer, Link, and Majcher-Angermeyer forthcoming; Link 1985). One such strategy is to try to teach others about psychiatric treatment in an attempt to counteract stereotypes. An implication of this strategy is that patients give up the possibility of keeping their history of treatment a secret. The attempt to educate can fail and employers can be affected unfavorably by knowledge of past treatment. Even if the education process is successful, patients are less likely to leave a job where they feel accepted; as a result, they lose leverage in asking for better pay in their current job. The active approach of educating others creates the risk of real discrimination and can have negative consequences for income, even when successful.

A second, possibly more harmful, defensive strategy is to withdraw to a group of what Goffman (1963) called the "own" (those similarly stigmatized) and the "wise" (those who understand and accept the stigmatized individual). Withdrawing has the benefit of sheltering patients from potential threats, but at the same time is likely to restrict their search for a job that pays well. Finding a good job often means contacting unknown others and using less personal weak ties (Granovetter 1973). When

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patients withdraw to protect themselves, they miss these potential sources of advancement.

Specific Hypotheses

This reasoning was tested by comparing data on five groups: (1) psychiatric patients experiencing their first treatment contact, (2) current psychiatric patients with multiple treatment contacts, (3) community residents who reported having had, but were not currently in, treatment, (4) community residents who were classified as untreated cases based on systematic evaluations of their symptomatology, and (5) community residents with no evidence of severe pathology and no history of treatment. Each of these groups was asked questions about whether or not they believed that most people would devalue and discriminate against a person who had been in psychiatric treatment. The importance of these beliefs for predicting the selected outcomes (demoralization, earned income, and work status) differed radically among the groups.

The five groups varied in three major ways. First and most important was whether the individual had been labeled by treatment contact. First treatment contact patients, repeat-treatment contact patients, and community residents who were in treatment at one time had all been exposed, whereas untreated community residents had not.

Second, the groups varied in their levels of psychopathology. Current patients, whether experiencing their first or a repeat treatment contact, were all experiencing severe psychiatric problems. Untreated cases were also experiencing levels of psychopathology high enough to resemble psychiatric patients on the measures employed (described below). Community residents who were once in treatment constituted a mixed group: some were currently well; others still qualified as cases. The remaining group of community residents showed no evidence of psychopathology and had never been in treatment.

Third, each of the treated group had a different experience with labeling. First-treatment contact patients had been exposed only recently. The experience was new for them, and if they believed that most people would devalue and discriminate against them, they might be affected powerfully. On the other hand, because their experience was new, factors such as income earned in the previous year could not have been affected by labeling. Repeat-contact patients differed from first contact patients in that they had a history of having been labeled, so that their earned income and employment could have been affected over time by expectations of rejection. In addition, because repeat-contact patients were currently in treatment, they differed from community respondents who were at one time but not currently in treatment. Clausen (1981) suggests that the salience of labeling effects is likely to dissipate with time, both in terms of patients' feelings about rejection and in their occupational careers (Huffine and Clausen 1979). Thus, although repeat-contact patients and formerly treated cases shared a history of psychiatric treatment, labeling effects were likely to be more salient among those who had returned to treatment.

In Table 1 effects are predicted only when a current label or a history of labeling is present. If absent, no effect is predicted even if considerable psychopathology is present. Moreover, the timing of the outcomes of labeling leads to different predictions about when beliefs about devaluation or discrimination will have an effect. Specifically, the prediction about demoralization is made for both first and repeat-treatment contact patients. In contrast, effects on income and work status are predicted only for repeat-contact patients because these variables are likely to be affected more slowly and are assessed for a period before first-treatment contact patients entered the clinic or hospital.

Two closely intertwined social psychological mechanisms—self-devaluation and concern about others' responses—may be involved in producing results consistent with the predictions in Table 1. The nature of the design, however, which yields predictions about labeling effects across variations in levels of psychopathology, ensures that whichever mechanism is operative, labeling must be involved. Thus, while it is not possible to isolate the precise social psychological mechanism at work, the design does produce a test of the importance of labeling.

If labeling and stigma are unimportant, as the critics claim, one would not expect to find *any* significant associations between beliefs about devaluation and discrimination and important outcome variables. Nor would one expect labeling to lead to different predictions about the effect of these beliefs on the outcome variables.

Finally, the strategy includes untreated (unlabeled) persons who are experiencing significant psychopathology. No effects of beliefs about devaluation and discrimination are predicted for this group since the label is not present to make the beliefs personally relevant. This omission runs counter to the emphasis that critics have placed on psychiatric condition rather than labeling as the real, even the sole, cause of negative outcomes for patients.

METHOD

Sample

This study reports results collected on a sample of community residents (N = 429) and

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Table 1. Hypothesized Effects of Beliefs about Devaluation and Discrimination

	First-Treatment Contact Patients	Repeat-Treatment Contact Patients	Formerly Treated Community Residents	Community Untreated Cases	Community Respondents Without Pathology
Distinguishing Features					
Currently in treatment?	yes	yes	no	no	no
Previous treatment?	no	yes	yes	no	no
Level of psychopathology?	high	high	mixed	high	low
Prediction concerning the effect of beliefs about devaluation-discrimination rejection on demoralization within the group.	Significant effect expected	Significant effect expected	Weak effect expected—residue of past labeling	No effect expected	No effect expected
Prediction concerning the effect of beliefs about devaluation-discrimination on employment and earned income.	No effect expected—no past history of a label	Significant effect expected	Significant effect expected but a smaller one than among repeat contact patients currently in treatment	No effect expected	No effect expected

psychiatric patients (N = 164) in the Washington Heights section of New York City between 1980 and 1983 (Dohrenwend, Shrout, Link, Martin, and Skodol 1986). The community respondents were obtained by following up a sample collected approximately six months earlier. In the original sample, households were enumerated through telephone directories and contacted to see if an eligible respondent between 19 and 59 years of age lived there. In 93 percent of the households, screening information was provided; 68 percent of these contained one or more eligible respondents. The goals of the original study were methodological, involving random assignment of respondents to two versions (one-month versus one-year recall of symptoms) of the Psychiatric Epidemiology Research Interview (PERI). Given this focus, the major effort was placed on testing the different forms of the PERI in contrasting ethnic and socioeconomic groups. Intensive efforts to interview hard-to-schedule respondents and to convert refusals were not undertaken initially. Later, when the substantive study was implemented toward the end of the methodological study, provision was made for checking on a subsample of "hard-to-schedule" subjects (N = 48).[1] In the end, 57 percent of the 943 eligible respondents in the original sample were interviewed successfully.

With respect to the representativeness of the sample, I reasoned that the hard-to-schedule respondents would be more like the larger pool of nonrespondents than the more easily obtained individuals. This reasoning seemed appropriate: without extensive effort these individuals would have been nonrespondents. As a result, they provide the best check available on the sample's representativeness. Hard-to-schedule respondents were compared to other community respondents in their opinions about the attitudes of most people toward mental patients. The means for the devaluation-discrimination scale were quite similar for hard-to-schedule and all other community respondents and not significantly different.

In addition to generating a sample of hard-to-schedule respondents, extensive efforts were initiated to ensure an adequate reinterview rate in the second wave of data collection. As a result, 79 percent of the initial sample (429) was located and reinterviewed.

The patient sample was selected from outpatient clinics and inpatient facilities in the same general area of New York City. The goal was to select patients in two diagnostic categories, major depression and schizophrenia and schizo-

[1] This group included 33 individuals who refused initially but were converted with intensive effort; 12 who failed to keep two appointments (our usual cutoff as a lost case) but were obtained on a third or later appointment; and 3 who could not be reached by telephone after eight attempts at different times of day (our usual cutoff as a lost case) but were reached on a ninth or subsequent attempt.

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phrenic-like psychotic disorders.[2] In addition, considerable effort was made to locate cases in their first episode of each of these types of disorder. Although it was extremely difficult to find first-episode schizophrenic cases, 164 patients were interviewed: 50 first-episode major depression, 21 first-episode schizophrenic, 48 repeat-episode major depression, and 43 repeat-episode schizophrenic.[3]

Study Groups

To form the five groups, distinctions on psychiatric status and labeling exposure were required. The group of untreated community respondents with no evidence of psychopathology ($N = 171$) was constructed by subjecting all respondents to extensive screening. First, their scores on seven symptom scales taken from the PERI interview needed to be low enough that they could be classified correctly as community respondents in a multiple-discriminant analysis (Shrout, Dohrenwend, and Levav 1986).[4] In addition, this group had never undergone mental-health treatment. Finally, in the second interview (the "risk-factor" interview), subjects who scored high on a six-month demoralization scale were evaluated by a modified form of the Diagnostic Interview Schedule (DIS; Robins, Helzer, Crougham, and Ratcliff 1981), a standardized interview that yields psychiatric diagnoses according to DSM-III criteria. No individual who was found to have a diagnosable psychiatric disorder on this interview was included in the group of community respondents without psychopathology.

The untreated community case group can be formed in two different ways. One uses multiple-discriminant analysis: a community case group is formed by community respondents who are "misclassified" in the analysis because they appear "just like" psychiatric patients in regard to the symptoms they express. The second incorporates diagnostic procedures and uses the results from the modified DIS to generate DSM-III diagnoses. Further, because the objective was to identify untreated cases, information on treatment history was used to remove community cases who had had contact with a mental-health professional (a psychiatrist, psychologist, or social worker) or who had been hospitalized in a mental hospital. The untreated group included individuals ($N = 142$) who had been identified either via the PERI discriminant function or the modified DIS. The analyses were also run in each group separately, however, to ensure that the results were consistent cross untreated case groups.

The group of recently labeled, first-treatment contact patients was generated from the community ($N = 11$) and the patient sample ($N = 56$). An individual was defined as a first-contact patient if his or her first treatment with a psychiatrist, a psychologist, or a social worker occurred within the year before the interview. In the cases obtained from the patient sample, it was possible to check this information against the diagnosing psychiatrist's report and clinical and hospital records. All sources of information were used in order to maximize the accuracy of the treatment history information.

The group of repeat-treatment contact patients ($N = 117$) was also generated from both the community ($N = 9$) and the patient ($N = 108$) samples. The small number of repeat-contact patients from the community consisted of individuals who reported their first contact to be years ago but who reported current treatment. The group from the patient sample consisted of individuals who were determined to have had a previous-treatment contact.

The past-treatment contact patients ($N = 96$) were all drawn from the community sample. They reported past contact with a mental-health professional, but were not currently in treatment. Because this group of "former patients" was derived from the community sample, some were less like our patient samples and more like the "friends and supporters of psychotherapy" as described by Kadushin (1969). Such individuals are more likely to have been in private treatment, where stigma is less of an issue, and

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[2] We refer to patients with combined schizophrenia and schizophrenia-like disorders as those with "schizophrenic disorder." The main difference between them is that symptoms must last six months or more for the diagnosis of schizophrenia in DSM-III—a relatively new and controversial distinction. The six-month criterion makes it extremely difficult to locate first-episode cases. As a result, most of our first-episode schizophrenic disorder patients (15 of 21) do not have a diagnosis of DSM-III schizophrenia but diagnoses such as "schizophreniform," which are consistent with clinical features of schizophrenia but do not require a six-month duration.

[3] First-episode and first-treatment contact are different. A person experiencing a first episode of schizophrenia or schizophrenic-like disorder may have been treated earlier for another problem. Similarly, a first-treatment contact patient may have had several untreated episodes and therefore may be classified as a repeat-episode patient. Because this paper focuses on labeling, treatment contact is the major variable employed.

Two patients were not placed into any of the four categories because the clinical information available on these patients was not sufficient to be certain of meeting DSM-III criteria for the disorders involved.

[4] The Shrout et al. (1986) procedure involves a multiple-discriminant analysis which attempts to classify subjects correctly from known groups on the basis of PERI symptom scale scores. The analysis includes various diagnostic groups from patient cases as well as community respondents. The subjects forming the well group are classified correctly as community respondents.

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are less likely to conceive of themselves as the type of patient who needs to fear rejection from others. In addition, because this group is formed from the community sample, the checks on treatment status from psychiatrists' reports and clinic and hospital records were not available. As a result episodes of treatment may not have been reported, particularly for those who fear rejection most.

Hypothesized Independent Variable—Beliefs about Devaluation Discrimination

The main independent variable in this study was measured by 12 items (see Appendix) that were written to assess the extent to which an individual believes most people will devalue or discriminate against a psychiatric patient (Link 1985). These items were asked in a 6-point "strongly agree" to "strongly disagree" Likert format and were administered to all individuals whether or not they had been labeled. The scale, which ranges from 1 to 6, is the result of summing the items and dividing by 12. It shows adequate reliability overall (α = .78) as well as among first-treatment contact patients (α = .79), repeat-contact patients (α = .82), former-patients (α = .83), untreated community cases (α = .73), and well members of the community (α = .73).

The validity of the measure of expectations of devaluation-discrimination rests largely on the face validity of the items composing it. Correlations between the scale and a measure of acquiescence are low and nonsignificant, however, in the overall sample and in the various subgroups, indicating that the construct tapped is not contaminated excessively by this form of method variance. In addition, the construct validity of the scale (Cronbach and Meehl 1955) will be enhanced if the operational measure behaves in accordance with the theory that led to the creation of the scale. This form of validity will be tested as I investigate the major hypotheses.

Dependent and Control Variables

Demoralization was measured using Dohrenwend et al.'s (1980) 27–item scale. The scale was administered at the same time as the perceived devaluation-discrimination measure and is composed of questions about the frequency of symptoms in the past six months. This measure captures the themes of low self-esteem, helplessness-hopelessness, confused thinking, sadness, and so forth that both Frank (1973) and Sullivan (1941) conceptualized as core components of demoralization. The scale is highly reliable in the sample as a whole (α = .95) and in each of the five study groups (range α = .92 to α = .95). The one exception is the well group, α = .82, which excludes highly demoralized individuals and therefore restricts the variance of demoralization.

Income was operationalized as the respondent's earnings from wages, salaries, and self-employment for the tax year preceding the year in which the risk-factor interview was conducted. Fifteen income categories were provided, ranging from under $3,000 to over $50,000. Each individual was assigned the dollar amount at the midpoint of his or her income category.

Employment status was determined by asking each respondent how many weeks they were unemployed during the past year. An individual could range from "0" on this scale, indicating no period of unemployment, to "52," indicating that no job was held during the previous year.[5]

A number of variables known to be related to demoralization, earned income, or both will be used as control variables in subsequent analyses. Particularly important for the analysis of demoralization are gender, marital status, education, ethnicity, and psychiatric diagnosis. In addition, the prediction of earned income and unemployment will involve controls for occupational prestige and age. Data in Table 2 show that substantial differences exist among the five groups on the control variables, indicating their potential importance in the following analyses. The five groups also differ greatly in the dependent variables (demoralization, earned income, and unemployment). These differences remain when controls for age, sex, education, marital status, and ethnicity are entered into a multiple regression (not shown).

RESULTS

The central question of this inquiry focuses on whether official labeling transforms beliefs about the devaluation and discrimination of mental pa-

[5] Variables such as demoralization, earned income, and weeks unemployed are often skewed positively. As a result they are frequently subjected to transformations (e.g., a log transformation) to make their distributions approximate the normal distribution more closely. In this paper, the key hypotheses focus on the effect of beliefs about devaluation and discrimination on these outcomes within five groups. As it turned out, demoralization was not skewed significantly in any of them. Unfortunately, unemployment and earned income varied in the extent of positive skew and at times were skewed negatively. Thus it was impossible to adopt a transformation that could be applied uniformly across the five groups. Because multiple regression is robust to violations of normality and because no ideal transformation could be applied uniformly, the variables were left in their original metric. For key analyses concerning income and unemployment, however, the results were run with natural-log transformations of the dependent variables. The results are reported in subsequent footnotes.

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Table 2. Social Characteristics of Five Study Groups (Maximum $N = 593$; Standard Deviations in Parentheses)

	First-Treatment Contact Patients	Repeat-Treatment Contact Patients	Former Patients	Untreated Cases	Untreated Community Well Respondents	Significant of F or Chi-Square Test of Group Differences
Control Variables						
Age (in years)	32.71 (13.31)	36.59 (11.56)	37.68 (11.84)	35.77 (12.26)	40.29 (12.47)	$F_{4,587} = 5.53$ $p < .001$
Education (in years)	12.46 (3.14)	12.38 (3.67)	13.46 (3.59)	11.78 (3.52)	13.28 (3.13)	$F_{4,587} = 5.25$ $p < .001$
Prestige of current or last occupation (Treiman scores)	38.19 (13.10)	41.92 (11.75)	43.22 (12.67)	39.89 (12.69)	43.99 (12.95)	$F_{4,588} = 3.77$ $p < .005$
Married	25.4%	18.8%	49.0%	44.4%	55.6%	$\chi^2_{8,584} = 53.70$ $p < .001$
Never Married	52.2%	43.6%	30.2%	34.5%	25.7%	
Divorced, widowed, or separated	22.4%	37.6%	20.8%	21.1%	18.7%	
Hispanic	26.9%	19.7%	18.8%	40.1%	24.0%	$\chi^2_{8,584} = 25.52$ $p < .001$
Black	35.8%	39.3%	28.1%	28.2%	30.4%	
White and other	37.3%	41.0%	53.1%	31.7%	45.6%	
Sex (percent female)	58.2%	70.9%	59.4%	64.4%	49.7%	$\chi^2_{4,588} = 14.11$ $p < .001$
Dependent Variables						
Demoralization (27-item PERI Scale)	2.87 (.73)	3.14 (.83)	2.48 (.69)	2.55 (.62)	1.84 (.34)	$F_{4,582} = 81.97$ $p < .001$
Respondent's earned income (in dollars formed by taking category means)	7,261 (7,263)	6,312 (6,038)	11,406 (9,201)	10,664 (8,811)	14,390 (10,282)	$F_{4,570} = 17.14$ $p < .001$
Unemployment (number of weeks unemployed)	24.52 (22.74)	30.44 (23.11)	13.55 (19.58)	17.31 (21.63)	9.97 (17.90)	$F_{4,587} = 19.59$ $p < .001$

Note: Different variables have different numbers of missing values. The degrees of freedom associated with the statistical tests indicate how many are missing for each variable.

tients into an expectation of rejection that can impair functioning. The predictions summarized in Table 1 are the main tests of this explanation.

Two preliminary issues that are important background for the more central tests that follow are addressed in Table 3, which reports a one-way analysis of variance with the five study groups as the predictor variable and the beliefs about devaluation-discrimination scale as the outcome. First, note that the mean levels across the five groups are significantly higher than the 3.5 midpoint of the scale. Consistent with the theoretical perspective, this finding suggests that acquiring the status of mental patient can imply grave consequences for people's beliefs about their standing in the community. Second, group membership explains only a trivial, nonsignificant amount of the variance (1.2%) in the devaluation-discrimination measure.[6] This finding indicates that people who vary considerably in their experience with labeling and in their levels of psychopathology share the belief that mental patients will be devalued and discriminated against. The key factor is whether these beliefs about devaluation and discrimination are made applicable to the individual by labeling.

Testing the main predictions of this study involves two major questions: first, whether the effect of the devaluation-discrimination measure on an outcome of interest (demoralization, earned income, employment status) is significant in those groups in which it is predicted to have an effect. This question examines whether beliefs about devaluation-discrimination are associated independently with the predicted negative outcomes. The second major question is whether the effects uncovered differ significantly from the effects in other groups. If the beliefs become salient only to labeled individuals, their effects in labeled groups should differ from those in unlabeled groups.

To investigate these two questions, I develop a model that includes only those control

[6] The "no strong group difference" result also held in a multiple-regression analysis entering the control variables listed in Table 2.

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Table 3. Effect of Five Study Groups on Beliefs about Devaluation and Discrimination

Group	Number of Cases	Mean Score on Devaluation-Discrimination Measure	Standard Deviation
First-treatment contact patients	61	4.03***	.86
Repeat-treatment contact patients	115	4.15***	.89
Former patients	95	4.33***	.92
Untreated cases	142	4.13***	.73
Untreated community well respondents	169	4.08***	.80

Analysis of Variance

Source	Degrees of Freedom	Sum of Squares	*F*-value	*P*-value
Between groups	4	4.65	1.69	.150
Within groups	577	396.03		

*** Mean significantly different from 3.5 midpoint at $p<.001$.

variables that independently predict the outcome of interest. The variable measuring beliefs about devaluation and discrimination is entered and evaluated in the context of this model. The rationale for excluding nonsignificant control variables is that they cannot be potent confounders unless they are related to the outcome. In addition, these questions are addressed first for demoralization and then for income and employment status considered jointly. The dependent variables are separated in this way because (1) the analysis of income and employment status excludes full-time students and retired persons, whose incomes cannot be affected by labeling, and (2) the control variables needed for income and employment status differ from those needed for demoralization.

Demoralization

Theoretically, expectations of devaluation and discrimination will affect people who have either recently been labeled for the first time or who have returned for treatment after their first contact. Those who were once in treatment but currently are not have been labeled and can potentially be affected. For these people, however, the effects of expectations of devaluation and discrimination have had time to dissipate, so this group will be analyzed separately.

First- and Repeat-Contact Patients. As indicated in Table 4 the effect of the devaluation-discrimination measure on demoralization is significant even after controls for other factors have been entered. Most of these controls are chosen from factors that have been shown in the literature to be associated with measures of psychological distress.[7] In addition to these

[7] Some of these predictors—sex, years of education, and employment status—are not significant among patients and therefore were not entered in Table 4. One reason why these variables are not important is that

Table 4. Effect of the Devaluation and Discrimination Measure on Demoralization in First and Repeat-Contact Patients ($N=174$)

	Unstandardized Regression Coefficient	Standardized Regression Coefficient	*t*-value	Significance
Control Variables				
Married (1) vs. unmarried (0)	−.322	−.163	−2.380	.018
Hispanic (1) vs. other (0)	.345	.173	2.515	.013
Hospitalized (1) vs. never hospitalized (0)	.377	.227	3.163	.002
Diagnosis of depression (1) vs. schizophrenia (0)	.486	.303	4.223	.000
Test Variable				
Devaluation-discrimination	.211	.232	3.35	.001
	$R^2=.232$			

Note: Of the 184 respondents who are experiencing their first-treatment contact or a repeat-treatment contact, 10 had missing values on either demoralization or devaluation-discrimination.

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variables, controls for a history of psychiatric hospitalization (1 = hospitalized, 0 = not hospitalized) and diagnosis (1 = depressed, 0 = schizophrenic) have been entered into the equation reported in Table 4. Those who have been hospitalized are more severely demoralized than those who have not. This could be due to a number of social factors but is also consistent with the notion that hospitalization is an indicator of severity of illness. Most important for the present inquiry, the measure of devaluation-discrimination remains significant after this control. The control for diagnosis is important because symptoms of demoralization are often similar to those required for a diagnosis of major depression. As a result, one would expect patients with depression to be experiencing higher levels of demoralization. The significant coefficient for a diagnosis of depression (as opposed to schizophrenia) shows that this is true, but again it does not account for the effect of beliefs about devaluation-discrimination on demoralization. Furthermore, when a cross-product term between diagnosis and beliefs about devaluation-discrimination is entered to test for interaction between the two variables, no significant effect is found. This result suggests a relatively constant effect across the two diagnostic groups. Thus, while diagnosis is related to the level of demoralization, the measure for beliefs about devaluation and discrimination is associated with higher levels of demoralization in both groups.

Former Patients. When other factors are constant, the devaluation-discrimination measure is not significantly related to demoralization among former patients. Furthermore, the very small effect present (not shown) has a negative sign, suggesting that higher perceptions of devaluation and discrimination are associated with lower levels of demoralization. It is possible, however, that this group of former patients contains "friends and supporters of psychotherapy" (Kadushin 1969) who have not been exposed to a strong labeling experience. Accordingly, an analysis was conducted which allowed an interaction between hospitalization (ever = 1 vs. never = 0) and the measure for expectations of devaluation-discrimination. The probability level of the cross-product term is .054 in a model containing only significant control variables. The coefficients from this analysis show that the effect of the devaluation-discrimination measure is relatively strong among those who have been exposed to the substantial labeling experience of hospitalization and weak and negative among those who have not. Thus, although based on small numbers, these results suggest that individuals who have been hospitalized may continue to be affected by expectations of devaluation and discrimination. There is no evidence that other "former patients" are affected in the same way.

Untreated Community Respondents. According to the predictions in Table 1, beliefs about devaluation-discrimination should have no effect in unlabeled groups, regardless of their levels of psychopathology. When significant controls are selected from the same variables used for the analysis of current patients, the regression coefficient for the measure of expectation of devaluation-discrimination among untreated community respondents (the well group and the untreated-case group) is close to zero and nonsignificant. When attention is limited to untreated cases who resemble patients in that they have relatively high levels of symptomatology, the regression coefficient is once again nonsignificant. The analysis was also run separately for the two different methods of defining untreated cases. In neither case did the effect of devaluation-discrimination even approach statistical significance.

Comparing the Effect of Devaluation-Discrimination across Groups. According to the hypothesis regarding activation of beliefs about devaluation-discrimination with respect to mental patients, the effect among patients should not only differ significantly from zero (as addressed above), but also should be significantly greater than the effect in unlabeled groups. This hypothesis implies that devaluation-discrimination and labeling status interact to affect demoralization. Such an effect can be evaluated in a regression model by examining the significance of the appropriate cross-product term.

To generate the strongest test of the hypothesis, groups that share a prediction of either a positive effect (repeat- and first-contact patients) or no effect (untreated cases, well controls) were combined (see Table 1). This combination was made, however, only after I tested the size of the effect of devaluation-discrimination on demoralization and found that it did not differ in the groups combined. The former-patient group was kept separate in the analysis because the hypothesis concerning it is different from the hypothesis concerning the other groups. Thus, three groups were employed in the analysis to test for interaction: (1) current patients (first- and repeat-contact groups), (2) untreated community residents (untreated cases and well

patients were selected into treatment partly because of their psychiatric problems. As a result, group differences evident in community studies may not exist in patient samples because the most severely distressed individuals from each group have been selected into treatment. Ultimately one is comparing the most seriously troubled persons from each group.

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controls), and (3) former patients from the community sample.

In Table 5, the suppressed category is the group of current patients who have formed the basis of the analysis so far. The coefficients of the cross-product terms give an estimate of how much must be added to or subtracted from the slope of the devaluation-discrimination measure in the current patients to reflect the value of the slope in a given unlabeled group. Thus, when other factors are held constant, the slope in the current-patient group is estimated to be .197 (see Table 5), whereas the slopes in the community untreated group and the former patient group are .001 and .026, respectively. These results also show that as a group former patients are much more like unlabeled community residents than like current patients regarding the implications of beliefs about devaluation-discrimination. In fact, they are almost significantly different from current patients. Most important, the beliefs about devaluation-discrimination have a significantly greater impact among currently labeled patients than among unlabeled community respondents. This result is not only consistent with the hypothesized effect but also indicates that the effect cannot be attributed to any crude confounding of the constructs involved. If demoralization and devaluation-discrimination measures tapped the same dimension, one would expect effects among the community untreated respondents to emerge as well.

Income and Work Status

In the analysis of income and employment status, three differences need highlighting. First, the analysis excludes individuals who have retired or who are full-time students because expectations of rejection cannot affect the income and employment status of these groups. Second, because this analysis includes two dependent variables, multivariate hypothesis testing (Finn 1974) was employed. Finally, the devaluation-discrimination measure is not expected to have an effect on the incomes or employment status of first-treatment contact patients. Only repeat-contact patients and former patients have spent sufficient time in the community with the label, which could cause them to suffer difficulties in these areas.

Repeat-Contact Patients. A multivariate regression analysis showing the effects of beliefs about devaluation-discrimination on income and number of weeks employed in the past year is presented in Table 6. To test these effects I generated a set of control variables that maximally predicted the two outcomes. In this regard, Table 6 includes cross-product terms between sex and marital status and sex and occupational prestige, which are important in predicting income. Diagnosis, ethnicity, and age were tested for inclusion in the model but were removed because they did not increase the prediction. When a set of control variables was determined, the devaluation-discrimination measure was added to examine whether it predicted the joint distribution of income and employment status. As shown, the multivariate test is

Table 5. Test for Differences in Slopes of the Devaluation and Discrimination Measure on Demoralization in Untreated Community Cases, Former Patients, and Current Patients

	Unstandardized Regression Coefficient	Standardized Regression Coefficient	*t*-value	Significance
Control Variables				
Female (1) vs. male (0)	.102	.064	1.89	.060
Hispanic (1) vs. other (0)	.140	.078	2.18	.030
Unemployed (1) vs. other (0)	.219	.114	3.19	.002
Years of education	−.019	−.085	−2.32	.021
Hospitalized (1) vs. never hospitalized (0)	.293	.131	3.32	.001
Depressed (1) vs. other (0)	.743	.380	7.12	.000
Psychotic (1) vs. other (0)	.261	.103	1.94	.053
Community untreated (1) vs. other (0)	.548	.348	1.77	.078
Community former patient (1) vs. other (0)	.673	.318	1.71	.087
Devaluation-discrimination	.197	.209	3.62	.000
Test Variable				
Devaluation-discrimination x community untreated	−.196	−.528	−2.74	.006
Devaluation-discrimination x community former patients	−.171	−.358	−1.94	.053
	$R^2 = .393$			

Note: Of the 593 respondents, 15 are excluded because of missing values on demoralization or devaluation-discrimination.

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Table 6. Impact of the Devaluation-Discrimination Measure on Income and Unemployment Status in Repeat-Contact Patients ($N=94$)

	Respondent's Earned Income		Unemployment		Multivariate Significance Test	
	Unstandardized Regression Coefficient	Standardized Regression Coefficient	Unstandardized Regression Coefficient	Standardized Regression Coefficient	*F*-value Pillai's Criterion	*p*-value
Control Variables						
Occupational prestige	−84.11	−.149	.28	.136	.496	.611
Years of education	697.06***	.360	−2.58**	−.370	7.603	.001
Sex (female = 1)	−9,113.19	−.648	26.97	.532	1.985	.144
Married (1) vs. unmarried (0)	11,345.66***	.793	−14.34	−.261	7.175	.001
Sex x married	−13,098.27***	−.749	21.45	.361	7.435	.001
Sex x occupational Prestige	224.37*	.761	−.58	−.547	2.127	.126
Test Variable						
Devaluation-discrimination	−1,535.80*	−.215	7.12**	.276	4.435	.015
	$R^2=.327$		$R^2=.214$			

Note: Of the 117 repeat-treatment contact patients, 14 were excluded because they were full-time students, 2 because they were retired, and 7 because they had missing values on earned income, unemployment, or devaluation-discrimination.

* $p<.05$.
** $p<.01$.
*** $p<.001$.

significant,[8] and the univariate regression coefficients show that the effect is significant for each dependent variable. When other factors are held constant, each point on the devaluation-discrimination scale (range 1–6, standard deviation = .89) is associated with a $1,536 decrement in income and 7.12 more weeks of unemployment.

Did these effects hold across the two diagnostic groups (schizophrenia and major depression) and for those who had been hospitalized as opposed to those who had been clinic outpatients only? I tested interaction models of diagnosis and past hospitalization by devaluation-discrimination. The interaction suggests that beliefs about devaluation-discrimination are slightly more important for the depressed group, but the multivariate significance test did not even approach significance. This finding is important because it weakens any argument that suggests that the form of pathology explains the association of devaluation and discrimination with income and employment status. The test for past hospitalization reveals that the devaluation-discrimination measure is more important for previously hospitalized cases, but again this effect is not significant. Thus, the implications of beliefs about devaluation-discrimination do not differ greatly across these groups.

Finally I considered the possibility that some of the patients who had been hospitalized might have been hospitalized in the year covered by the questions on income and employment. While hospitalizations are now considerably shorter than in the past, one would still expect hospitalized patients to have earned less income and to have been employed fewer weeks than nonhospitalized patients. Unfortunately, detailed hospitalization histories were not collected routinely. To threaten the validity of the findings reported in Table 6 such recent hospitalization experience would have to be related not only to the outcome measure but also to the devaluation-discrimination measure. Because the correlation between hospitalization and devaluation-discrimination is only .03 and is controlled for in the analysis, the possibility of serious confounding is weakened.[9] Nevertheless, the interviews of all individuals who had ever been hospitalized were reviewed. By using data on life events, employment history, and verbatim material recorded by the interviewer, it was possible to determine whether an individual

[8] This analysis was also conducted with log transformations of the dependent variables. The multivariate test of the effect of the devaluation-discrimination measure remained significant ($F_{2,85} = 4.452$, $p = .014$).

[9] The slight relationship between hospitalization and expectations of devaluation discrimination is not unexpected. According to the theory, these beliefs develop during socialization and labeling makes them applicable to the labeled individual. Thus one would not necessarily expect hospital cases to differ from clinic cases in regard to the mean level of these beliefs.

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had been in the hospital in the period covered by the income and employment questions. The 19 cases hospitalized in the relevant period were removed from the analysis and the model in Table 6 was reestimated. The coefficients reflecting the effect of the devaluation-discrimination measure changed very little.

Former Patients. When I used the same controls that I had employed to analyze repeat-treatment contact patients, the results for former patients showed that the devaluation-discrimination measure had no significant effects on the joint distribution of income and employment status. The effects are in the expected direction (for income, $b = -643$; for unemployment, $b = 2.31$), but are not significant. Further, the interaction of previous hospitalization and the devaluation-discrimination measure, which revealed effects on demoralization, did not even approach significance when tested for its effect on income and employment status.

First-Treatment Contact Patients, Untreated Cases, and Community Respondents Without Psychopathology. As predicted, the devaluation-discrimination measure has no significant effects on the joint distribution of income and unemployment in any of the unlabeled groups. When I used the same controls as in the repeat-admission cases, the results showed effects quite close to zero for the first-treatment contact, untreated cases, and community respondents with no psychopathology. Once again, separate analyses for the two different ways of defining untreated cases showed that the measure of expectations of devaluation/discrimination had no effect in either group.

Comparing the Effect of Beliefs about Devaluation-Discrimination on Income and Unemployment across Groups. The following analysis examines whether the significant effect of beliefs about devaluation-discrimination in the repeat-contact group is greater than in groups whose income and level of unemployment could not have been affected. The most powerful test of the hypothesis involves a comparison of the repeat-contact patients with all groups in which an effect is not expected. Thus, in Table 7 the repeat-contact patients are used for the suppressed category so that the significance tests of the interaction effects show whether the effect of devaluation-discrimination in one of the other groups differs from that among the repeat-contact patients. Because repeat-contact patients are expected to differ from both untreated community residents and first-contact patients, the multivariate hypothesis testing combines these two effects.

Data in Table 7 show that the effects of devaluation-discrimination are different in the relevant groups at a marginal level of statistical significance.[10] Estimates of the slope of the devaluation-discrimination measure on income and unemployment are all in the expected direction. When repeat-contact patients believe that mental patients will suffer devaluation and discrimination, they earn less income and are unemployed for more weeks; other groups tend not to show such effects.

DISCUSSION

Alternative Explanations Consistent with Criticisms of Labeling

The results of this paper run counter to the assertions of critics of labeling theory—labeling and stigma are associated with important domains of patients' lives. Unless these associations can be shown to be the spurious result of factors that critics have specified clearly, we must view as premature the idea that labeling and stigma are unimportant.

Typically, the most challenging alternative explanations to results showing a "labeling effect" turn on questions of the adequacy of controls for psychiatric condition between labeled and unlabeled groups. Is a supposed labeling effect real or is it simply a product of the failure to control adequately for the true cause—a patient's psychiatric condition? This research addresses the issue in three ways. First, tests *within* labeled groups of comparable psychiatric condition were accomplished by developing a measure of beliefs about devaluation-discrimination. Most of the difficulty in interpreting labeling effects comes when one attempts to equate labeled and unlabeled groups statistically on psychiatric condition (Link 1982). Second, there is no compelling reason to link severity of psychiatric condition to beliefs about how much rejection a mental patient is likely to experience. According to labeling theory, these beliefs develop early and have their source in the culture rather than developing as a consequence of severe symptomatology. Moreover, groups that differed radically in psychiatric condition (e.g., repeat-contact psychiatric patients and community wells) were

[10] When this analysis was run with log-transformed dependent variables, the significance level of the multivariate test of interaction changed very slightly to $p = .065$. Unfortunately, this change shifted the p-level above the .05 standard. Although neither p-value can be identified as "correct," it is best to adopt a conservative stance and point out that the effect with the use of the untransformed variables is marginal. Nevertheless, the effects are in the predicted direction. Thus, even if we consider $p = .065$ from the log-transformed analysis, the reported p-level is conservative with respect to the choice of a two-tailed rather than a one-tailed test.

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Table 7. Test for Differences in Slopes of the Devaluation-Discrimination Measure on Income and Unemployment ($N=493$)

	Respondent's Earned Income		Unemployment		Multivariate Significance Test	
	Unstandardized Regression Coefficient	Standardized Regression Coefficient	Unstandardized Regression Coefficient	Standardized Regression Coefficient	*F*-value Pillai's Criterion	*p*-value
Control Variables						
Untreated community case (1) other (0)	708.184	.038	−1.135	−.027	.014	.986
Former patients (1) other (0)	1,073.791	.043	−.461	−.008	.021	.979
First treatment contact (1) other (0)	−8,063.831	−.260	40.076*	.568	3.388	.035
Occupational prestige	165.850***	.222	−.031	−.018	8.401	.000
Years of education	717.533***	.261	−1.131***	−.180	19.095	.000
Sex (female = 1)	−3,042.602	−.160	21.191***	.491	5.803	.003
Currently married (1) other (0)	3,903.546***	.209	−2.695	−.063	6.293	.002
Age	131.946***	.178	−.162	−.096	11.196	.000
Sex x currently married	−6,502.107***	−.305	5.847	.121	10.685	.022
Sex x occupational prestige	−8.536	−.021	−.358	−.384	3.851	.022
Devaluation-discrimination	−1,369.525	−.123	5.714	.226	3.712	.025
Former patient x devaluation-discrimination	700.145	.125	−4.170	−.327	.896	.409
Test Variables						
Untreated community resident x devaluation-discrimination	1,120.020	.256	−3.681	−.370	2.53	.039
First treatment contact x devaluation-discrimination	2,447.699	.327	−11.684**	−.686		
	$R^2=.394$		$R^2=.254$			

Note: Of the 593 respondents, 51 were excluded because they were full-time students, 15 because they were retired, and 28 because they had missing values on earned income, unemployment, or devaluation-discrimination.

* $p<.05$.
** $p<.01$.
*** $p<.001$.

nonetheless indistinguishable on the measure of expectations of devaluation-discrimination. Thus, when the measure of these beliefs shows an association with an outcome measure, an assertion that this is due to psychiatric condition is extremely weak. The lack of association between psychiatric condition and the devaluation-discrimination measure shows that the former cannot be a potent confounder. Finally, the study design included individuals with schizophrenia and major depression, two severe but very different types of disorder. Not only did the effect of the devaluation-discrimination measure hold when diagnosis was controlled, but more importantly, the inclusion of an interaction term between the two variables was consistently nonsignificant across the dependent variables. This finding indicates a relatively constant effect across these two types of disorder and weakens any claim that the observed association of devaluation-discrimination with an outcome is due to a particular type of pathology.

Alternative Explanations in General

Definitive statements about cause are hard to draw on the basis of a single nonexperimental study (Cook and Campbell 1979). Therefore, it is important to make explicit potential counter-explanations that may be compatible with the data. Such discussion may facilitate the subsequent inquiry into these potential alternative explanations so that the perspective developed in this paper can be tested even more stringently in the future.

The most plausible alternative explanations reverse the direction of cause. That is patients who are more demoralized are more likely to fear rejection from others. Similarly, patients who have earned less income and have been unemployed explain their situation by believing that others reject them. To be persuasive, these counterexplanations must include labeling as a variable because the outcomes of interest are related to the devaluation-discrimination measure only in labeled groups.

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Although it is impossible to rule out these counterexplanations without clear evidence about time order, two factors suggest that they are less plausible than the labeling explanation. First, one must employ two explanations, one for demoralization and one for income and unemployment, to cover all the findings. The alternative explanation for the demoralization result posits the dominance of internal feelings of hopelessness, self-derogation, and the like, driving individuals to beliefs about the social rejection of mental patients. The counterexplanation for the income and unemployment finding posits the dominance of external events—failure in the job market—as the cause of these beliefs. It is possible that one mechanism may operate in one instance and a radically different one in another. Yet, other things being equal, a single explanation for the entire array of results is more parsimonious and more compelling.

A second problem with these counterexplanations emerges when one considers what else should be true if these alternatives are correct. Enormous gaps exist between labeled and unlabeled groups in all three outcome variables (see Table 2). Thus one could reasonably expect that if people fear devaluation and discrimination more when they are demoralized, and if they need to explain failure in jobs by positing that others are rejecting them, then patients should perceive considerably more rejection. Even so, to take one example, repeat-contact patients earn substantially lower incomes than members of other groups, but their beliefs about devaluation-discrimination are no higher than those of well members of the community (see Table 3). This finding remains when controls for sociodemographic variables are entered in a multiple regression (not shown). Similar logic holds for demoralization and unemployment status. Thus counterexplanations that reverse the direction of cause are inconsistent with the fundamental facts one would expect to find if such alternatives reflected the causal process that produced the data. Future work, which either extends the strategy employed above to other outcome variables or embeds the notion of expectations of rejection in an experimental intervention, is needed to strengthen the causal status of this perspective.

Implications Concerning the Labeling Debate

Several implications are contained in results which suggest that labeling can have important consequences. Three issues involve (1) the activation of beliefs about mental patients through treatment contact, (2) the relative importance of behavior as opposed to labeling as the cause of rejection, and (3) the role of labeling in producing secondary deviance.

First, the findings of this paper indicate that labeling evokes beliefs about how mental patients will be treated. If it did not—that is, if patients could convince themselves that they were exempt from being treated as "mental patients"—there would be no reason to expect the results I reported. Thus these findings are not compatible with the assertion that the term *mental patient,* as opposed to *psychiatric patient* or *anxiety clinic patient,* is too general to apply to patients at psychiatric clinics and hospitals.

Equally important are the results among former patients which suggest that the salience of beliefs about devaluation-discrimination diminishes with time, but strong conclusions in this regard need to be qualified. One reason is that former patients came from the community sample and may not have experienced as potent a labeling experience as individuals from the patient sample. Another is that the result is a failure to find a significant effect rather than a definitive finding of a zero effect; an effect may exist that is too small to be detected given the available sample size (Cohen 1977). Even with these qualifications, however, no strong evidence for the continuing effects of expectations of rejection was uncovered.

Second, some critics of labeling have found support in the results of experimental studies which show that behavior is a stronger predictor of rejection than labeling. Lehman et al. (1976) used videotapes to present the behavior of a confederate as normal, depressed withdrawn, or anxious neurotic, and to show that this behavior was much more important in producing negative evaluations than a reference to a psychiatric hospitalization (see Link et al. forthcoming). If the formulation presented is correct, however, labeling may cause demoralization (which contains components of anxious and depressive symptomatology) and thus produce the very behavior for which a person is then rejected. Because experimental studies artificially make labeling uncorrelated with behavior, they miss the possibility that labeling may be a more distal cause of rejection. As such, they do not provide unqualified support to the critics of labeling.

Third, one of the most hotly contested aspects of the labeling debate is whether labeling can produce secondary deviance. This paper, with the modifications it makes in labeling theory, provides evidence that generally supports the labeling position on this issue. In particular, the results concerning symptoms of demoralization provide an example consistent with Lemert's (1967) classic definition of secondary deviance as a "defense, adaptation, or attack" to being labeled. Although these symptoms are not the full-blown manifestations of mental disorder specified in Scheff's (1966) formulation of the consequences of labeling, they are considered

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widely in psychiatric evaluations. The linking of a modified labeling perspective to the emergence of these symptoms is a direct empirical challenge to critics of labeling theory on this issue.

In addition, the potential implications of the findings are important for explaining the course of major mental disorders. If psychiatric patients are affected in the ways suggested, it is likely that those who fear rejection most have been depleted both internally and externally by their experience. They suffer the lower self-esteem and hopelessness associated with demoralization; they have less income and cannot benefit from the sustenance of a work context. Thus they are exposed to conditions that psychosocially oriented researchers have indexed as important in the etiology of mental disorders (Dohrenwend and Dohrenwend 1981; Pearlin, Menaghan, Lieberman, and Mullan 1981; Brown and Harris 1978). If factors associated with labeling influence the levels of potent risk factors, labeling can be linked, at least potentially, to the persistence of major disorders such as schizophrenia and major depression. To summarize, the results presented are important for understanding how labeling can produce pejorative effects and for further investigation into the causes of the persistence of disorders. As such they suggest that labeling theory still provides a useful theoretical framework for understanding the role of social factors in mental disorders.

Appendix. Items in Devaluation-Discrimination Measure

1. Most people would willingly accept a former mental patient as a close friend
2. Most people believe that a person who has been in a mental hospital is just as intelligent as the average person
3. Most people believe that a former mental patient is just as trustworthy as the average citizen
4. Most people would accept a fully recovered former mental patient as a teacher of young children in a public school
5. Most people feel that entering a mental hospital is a sign of personal failure (R)
6. Most people would not hire a former mental patient to take care of their children, even if he or she had been well for some time (R)
7. Most people think less of a person who has been in a mental hospital (R)
8. Most employers will hire a former mental patient if he or she is qualified for the job
9. Most employers will pass over the application of a former mental patient in favor of another applicant (R)
10. Most people in my community would treat a former mental patient just as they would treat anyone
11. Most young women would be reluctant to date a man who has been hospitalized for a serious mental disorder (R)

Appendix. (Continued)

12. Once they know a person was in a mental hospital, most people will take his opinions less seriously (R)

Note: All items are answered using a 6-point strongly agree (1) to strongly disagree (6) format. In items followed by an (R), the scoring is reversed.

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